

time of diagnosis or very shortly afterwards. Two thirds of these (69.5%) were discharged on LMWH but the remainder (30.5%) were discharged on warfarin. Perhaps unsurprisingly, a similar percentage of the consultant physicians who completed the internet-based survey said they would prescribe LMWH, although a sizeable proportion continue to prescribe warfarin.

Conclusion NICE guidance is largely being adhered to but a proportion of clinicians continue to prescribe warfarin despite there being good evidence that LMWH is associated with a reduced risk of VTE recurrence in this group.² Further investigation is needed to determine whether this pattern of prescribing is prevalent throughout the UK, and why the guidance is being ignored in our Trust.

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P151 V-DIMERS STUDY - VALUE OF D-DIMERS IN ESTIMATING RISK OF SIGNIFICANT PULMONARY EMBOLISM AND DEEP VEIN THROMBOSIS

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Hypothesis The risk of Venous Thromboembolism (VTE) including Pulmonary Embolism (PE) increases proportionately with the level of d-dimers.

Introduction The risk of PE/VTE is low when the values of d-dimers are below the reference range (1) (<500 ng/ml in our hospital). There is no clear evidence to suggest that risk of VTE increases proportionately with rising levels of d-dimers. We studied the correlation between the various values of d-dimers and the associated risk of having a PE/VTE.

Methods Data was collected retrospectively from March 2011 to Feb 2012. For the study we divided the patients into 3 risk groups based on d-dimers. Group 1: 500–1000; Group 2: 1000–5000; Group 3: >5000. Each group was analysed by separate individual. Data was collected by selecting only those patients who had definitive scan to investigate for PE/VTE **Results**

See Table When d-dimers are >5000, the risk of PE/VTE is significantly elevated when compared to <5000. (p value <0.0005)

When the d-dimers are > 5000, it's a good predictor of central PE (p value <0.0005) or Proximal DVT (p value <0.0005).

Results

Abstract P151 Table 1.

	Total Cases	Positive VTE	PE		DVT	
			Central	Peripheral	Proximal	Distal
Group 1	195	16 (8%)	0 (0%)	4 (6.25%)	2 (1.5%)	10 (7.6%)
Group 2	221	34 (15.3%)	4 (5.4%)	7 (9.4%)	7 (4.7%)	16 (10.8%)
Group 3	122	81 (66.4%)	19 (46.3%)	5 (12.2%)	45 (55.5%)	12 (14.8%)

Conclusion Our study suggests that when the d-dimers are significantly elevated (>5000) the associated risk of VTE (PE and DVT) is significantly elevated. The risk appears to increase

proportionately until the value of 5000 beyond which it increases exponentially. Levels >5000 strongly predicts the likelihood of a central PE or a proximal DVT. Clinicians could use this as an additional indicator to thrombolysse PE's in absence of confirmatory test. Further validity studies will be required to confirm this.

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P152 PULMONARY EMBOLISM RULE-OUT CRITERIA IN CLINICAL PRACTICE

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Suspected pulmonary embolism (PE) is a common reason for referral to the medical team on call. The pulmonary embolism rule-out criteria (PERC) is a validated scoring system to identify patients at low risk of PE, allowing for possible discharge from the Emergency Department (ED) prior to referral. It is potentially advantageous over the modified Well's score (MWS) for PE, as a D-dimer result is not required.

We aimed to investigate two practice models: the PERC and the MWS in the investigation of suspected PE.

Those patients referred to the medical team on call by the University Hospital Lewisham ED with a suspected PE were identified over a 3 month period (January to March 2012). Further information was gathered on each patient by review of their ED notes. Patients who did not meet all 8 PERC criteria or had a MWS >4 were considered to be at high risk for PE.

94 patients were identified. The mean age was 53 years (range 18–92) and 68 were female (72%). 9 PEs were diagnosed.

13/94 patients met all PERC criteria, among these no PEs were diagnosed. This group underwent 10 D-dimer tests (70% positive), 2 CTPAs, and 3 V/Q scans. The overall length of stay directly related to waiting for these tests was 6 days, with a mean admission length of 1.3 days per patient. When all PERC criteria were not met due to age (>50 years) alone, the D-dimer proved an excellent 'rule-out' test, as the 2 patients in this cohort with PEs, had strongly positive D-dimer results.

Using MWS, 32/94 patients scored >4. Among this group there were 4 confirmed PEs (13%) and 1 indeterminate V/Q result. In the 62 patients with a MWS =4 there were also 4 confirmed PEs (6%), each with a positive D-dimer.

PERC is a useful scoring system to identify patients unlikely to have a PE and seems advantageous over the MWS in terms of reducing unnecessary admissions and investigations, while maintaining patient safety. When the PERC criteria are not met due to age alone, a negative D-dimer may also be an effective 'rule-out' option.

P153 MANAGING SUSPECTED PULMONARY EMBOLISM: APPLYING AN EFFECTIVE AMBULATORY EMERGENCY CARE STRATEGY

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